* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 202 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC 22 PM 1:13

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): RAMON D. MARTINEZ, SR.	2 SEX: MALE	3a TIME OF DEATH: 9:05 P M	3b DATE OF DEATH (Month, Day, Yr.): AUGUST 25, 1997		
4 *SOCIAL SECURITY NUMBER: 465 - 62 - 9570 8916 0	5a AGE—Last Birthday (Years): 59	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr.): APRIL 7, 1938	7 BIRTHPLACE (City and State or Foreign Country): NUEVO LAREDO, MEXICO
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? Unavailable	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient MORRIS ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence			
9b FACILITY NAME (If not institution, give street and number): ST CATHERINE HOSPITAL	9c CITY, TOWN OR LOCATION OF DEATH: EAST CHICAGO	9d COUNTY OF DEATH: LAKE			
10 MARITAL STATUS (Specify): DIVORCED	11 SURVIVING SPOUSE (If wife, give maiden name): N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STEELWORKER	12b KIND OF BUSINESS/INDUSTRY: INLAND STEEL CO.		
13a RESIDENCE—STATE: INDIANA	13b COUNTY: LAKE	13c CITY, TOWN OR LOCATION: EAST CHICAGO	13d STREET AND NUMBER: 3833 ALDER STREET		
13e ZIP CODE: 46312	13f INSIDE CITY LIMITS ☐ No ☒ Yes; 13g ON A FARM? ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.): MEXICAN	16 RACE—American Indian, Black, White, etc. (Specify): WHITE	17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 - 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): JOSE M. MARTINEZ	19 MOTHER'S NAME (First, Middle, Maiden Surname): ESPARANZA LOPEZ

INFORMANT

20a INFORMANT'S NAME (Type/Print): NANCY M. MARTINEZ	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3733 GRAND BLVD., EAST CHICAGO, IN	20c Relationship: DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): AUGUST 29, 1997 NW INDIANA CREMATION SERVICE	21c LOCATION—City or Town, State: CROWN POINT, INDIANA	
22a EMBALMER'S NAME: CHARLES W. WELLS	22b EMBALMER'S LICENSE NO: FD01024372	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR: David J. Pastrick	24b LICENSE NUMBER (of Licensee): FD08800012	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: OLESKA-PASTRICK FUNERAL HOME 155 3934 ELM STREET, EAST CHICAGO, IN	

CAUSE OF DEATH

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

FILED

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	CIRRHOSIS	
DUE TO (OR AS A CONSEQUENCE OF) b.	END STAGE LIVER DISEASE	
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

DEC 2 1997

SAM ORLICH
AUDITOR LAKE COUNTY

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

#30-325-98

CERTIFIER

29a CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ CORONER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Mylene Mangahas MD	0104512	8/26/97

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MYLENE MANGAHAS MD - 4716 INDIANAPOLIS BLVD EAST CHICAGO IN 46312

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
~~Mylene Mangahas MD~~ DR. Timothy RayKovich	8-26-97

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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